STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	A. BUILDING 00			
		155089	B. WIN	G		01/31/	2013
NAME OF P	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	ROVIDER OR SOLVER				20TH ST		
HERITAG	GE HOUSE OF NEV	V CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
F0000	Complaints INC IN00123588. Complaint IN00 Substantiated. deficiencies relare cited at F20 Complaint IN00 Unsubstantiate evidence.	D122784 - Federal/state ated to the allegations D1 and F203. D123588 - Id due to lack of January 30 and 31, T: 000035 er: 155089 100266250 RN TC RN M ms RN D13)	F00	00	F0000Preparation and/or execution of This Plan of Correction in general or any corrective action set forth here in particular, does not constitut an admission or agreement by Heritage House of New Castle the facts alleged or the conclusions set forth in the statement of deficiencies. The Plan of Correction and specific corrective actions are prepared and/or executed solely becaus of provisions of federal and/or state laws. Heritage House desires this Plan of Correction be considered the facility's Allegation of Compliance. Compliance is effective Sept. 3 2012. This building respectfully requests consideration for pap compliance from the Plan of Correction.	of of dee	
	Census payor t Medicare: 6	type:					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

000035

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2013 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155089	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/31/2013
	ROVIDER OR SUPPLIER SE HOUSE OF NEW CASTLE	1023 N	ADDRESS, CITY, STATE, ZIP COD 20TH ST ASTLE, IN 47362	E
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE COMPLETION
	Medicaid: 40 Other: 10 Total: 56			
	Sample: 3			
	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.			
	Quality review 2/06/13 by Suzanne Williams, RN			

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Event ID: CQEJ11

Facility ID: 000035

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED			
		155089	B. WING		01/31/2013		
				ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER						
LIEDITAC		N CACTLE	1023 N 20TH ST				
HERITAG	GE HOUSE OF NEV	VCASTLE	NEW C	ASTLE, IN 47362			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
F0201 SS=D	OF RESIDENT The facility must premain in the facility discharge the resunless the transferencessary for the	TRANSFER/DISCHARGE permit each resident to lity, and not transfer or ident from the facility er or discharge is resident's welfare and the cannot be met in the					
	because the reside sufficiently so the the services provious. The safety of individuals are sufficiently sufficiently and sufficiently	scharge is appropriate dent's health has improved resident no longer needs ided by the facility; viduals in the facility is					
	otherwise be end. The resident has and appropriate repaid under Medicathe facility. For a eligible for Medicanursing facility, the charge a resident under Medicaid; of the second seco	failed, after reasonable notice, to pay for (or to have are or Medicaid) a stay at resident who becomes aid after admission to a le nursing facility may conly allowable charges or					
	review, the faci resident to rem discharged the appropriate rea	view and record ility failed to permit a ain in the facility and resident without an	F0201	F201 1) Resident #A is no long a resident of the facility.2) All residents who are discharged from the facility have the poter to be affected. All residents w be permittedto remain in the facility and not be transferred discharged unless the transfer discharge is necessary for the residents welfare and the	ntial ill or		

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Event ID: CQEJ11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		155089	A. BUII B. WIN			01/31/	2013
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			20TH ST		
HERITAG	GE HOUSE OF NE	W CASTLE			ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION				(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings include:				resident's needs cannot be me	et in	
]				the facility; The transfer or		
	Resident #A's record was reviewed				discharge is appropriate becau	use	
					the resident's health has		
		2:33 P.M. Diagnoses			improved sufficiently so the		
		vere not limited to,			resident no longer needs the		
		ctive pulmonary			services provided by the	lo in	
	l ,	D), pulmonary fibrosis,			facility; The safety of individua the facility is endangered; The		
	oxygen depend	dence, and depression.			health of individuals in the faci		
					would other wise be	,	
	Resident #A's quarterly Minimum Data Set assessment dated 10/29/12,				endangered; The resident has		
					failed, after reasonable and		
	indicated Resident #A was				appropriate notice, to pay for(or	
					to have paid for under Medica	re	
		d had the ability to			or Medicaid) a stay at the facil	ity.	
		ners. He scored 13 on			For a resident who becomes		
	his Brief Intervi	iew for Mental Status,			eligible for Medicaid after		
	which indicated	d he was cognitively			admission to a nursing facility,	tne	
	intact.				nursing facility may charge a resident only allowable charge		
					under Medicaid; or The facility		
	A RT (Respirat	tory Therapy) Progress			ceases to operate. 3) All		
		ent #A dated 11/12/12			discharged resident will be		
		ndicated the following:			monitored for the reason for		
	· ·	•			transfer/ discharge and require	ed	
		vas notified by nursing			reasons for transfer or		
		evel positive airway			discharges: All residents will b	_	
	I -	helps the user get			permitted to remain in the facil	ity	
		neir lungs) order			and not be transferred or	or	
	change. The t	herapist reviewed and			discharged unless the transfer discharge is necessary for the		
	verified the ord	lers. The settings were			residents welfare and the		
	changed to 14	7 as ordered.			resident's needs cannot be me	et in	
	_	formed the therapist he			the facility; The transfer or		
		ssure settings should			discharge is appropriate becau	use	
	still be higher.	•			the resident's health has		
		•			improved sufficiently so the		
		ident #A use the			resident no longer needs the		
	I	ered and evaluate after			services provided by the facilit		
	_	5 days. Resident #A			The safety of individuals in the		
	understood an	d agreed.			facility is endangered; The hea	aith	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00 COMPLETEI			
		155089	B. WIN	NG		01/31/2013	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
			1023 N 20TH ST				
HERITAC	GE HOUSE OF NEV	V CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	` `	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			
TAG	A Nurses note 12/1/12 at 7:05 Resident #A co of breath. His 73% on 3 liters #A received an treatment and anxiety. An ord send Resident for evaluation at A Social Service local hospital in 12/3/12 at 2:00 informed by the Designee (SSE Care Facility (Eaccepting Resident #A sure Resident #A sure Resident #A sure Resident #A resupport with Bi compliant with settings had to self adjusting the Physician's ord until the out of Therapy compared.	ce (SS) note from the indicated the following: P.MSS had been e Social Service O) at the Extended ECF), they would not be dent #A back upon rge. Expect of the following: Infered from COPD. Inquired respiratory Pap. He was poorly the Bi-Pap. His Bi-Pap be locked due to him		TAG	of individuals in the facility woo other wise be endangered; The resident has failed, after reasonable and appropriate notice, to pay for(or to have performed for under Medicare or Medicais stay at the facility. For a reside who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility, the nursing facility allowable charges under Medicaid; or The facility cease operate. 4) Social Services with monitor all discharges/transfer residents to ensure they are being transferred/ discharged the appropriate reasons. The Social Service Designee or the Designee will be responsible fauditing all resident discharge/transfer for appropriate reasons for discharge/transfer. They will audit for 90 days all discharge/transfer; then week for 4 weeks, then monthly for months, then as needed. Any discrepancy will be reported to the QA Committee in the Quarterly QA Meeting.	aid d) a ent cility es to II of for eir or iate r.	
		ician and facility's ley were not meeting					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155089	B. WIN			01/31/	2013
NAME OF I	NOT HOLD ON OTHER RE	<u> </u>	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	K		1023 N	20TH ST		
HERITAG	GE HOUSE OF NE	W CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		n a respiratory stand					
	l '	he would be better					
		cility will full time on site					
	respiratory the	erapy.					
	A SS note for	Resident #A dated					
		0 P.M., indicated the					
		as concluded that					
	_	piratory needs could not					
	be met at this	•					
		and Social Service					
		D) had visited Resident					
		ospital to inform him of					
		"Staff expressed the					
		ent and that his personal					
		ould be transferred to					
	-	acility. Resident					
		acility. Resident					
		pt that his needs could					
		efficiently at another					
	1	surance offered."					
		daughter was notified					
		this decision with no					
	problem.						
	SS notes from	the local hospital					
		following: 12/4/12 at					
		sident #A was seated at					
		e bed. He was alert,					
		able to make informed					
	· · · · · · · · · · · · · · · · · · ·	had confirmed he					
		irn to the ECF he had					
		red to the hospital from.					
		ed to the hospital from. ed continuous oxygen					
	and breathing	treatments at the ECF.					

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Event ID: CQEJ11

Facility ID: 000035

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155089	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/31/2013
	PROVIDER OR SUPPLIER GE HOUSE OF NEW CASTLE	1023 N	ADDRESS, CITY, STATE, ZIP CODE 20TH ST ASTLE, IN 47362	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	The hospital Nurse Practitioner (NP) confirmed there was not a need for Resident #A to be in a facility where there was a RT (Respiratory Therapist), which had been the recommendation of the ECF. SS would follow-up with the ECF since Resident #A wished to return there upon discharge. 12/4/12 at 3:30 P.MSS spoke with ECF's Director of Nursing (DoN) and Administrator. SS was informed the ECF would not be accepting Resident #A back due to his respiratory needs, even though the ECF was aware the NP coordinating his hospital care, had confirmed it would not be necessary to have Resident #A in a ECF with a RT, once he was medically cleared for return. SS was present when the ECF Administrator and SSD presented to inform Resident #A they would not be accepting him back. 12/4/12 at 5:50 P.MSS had received a referral from nursing related to Resident #A was upset and anxious because the ECF was not accepting him back. Resident #A had stated the ECF had been his home for 3 years and his friends, caregivers, and nursing staff had become like family to him. Resident #A had indicated he had the Ombudsman's phone number and			

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Event ID: CQEJ11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155089		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 01/31/	ETED	
NAME OF I	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE	0 0	2010
HERITAG	GE HOUSE OF NEV	V CASTLE			ASTLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	not being acce besides respiral Resident #A had daughter and swas not aware accepting him options with Resident #A, a cited by his preto accepting him 12/5/12 at 9:15 Resident #A. If frustration relating to accepting him 12/5/12 at 9:15 Resident #A. If frustration relating to considere ferral was colocal ECF, which first choice of 12/5/12 at 10:4 the new ECF of 12/5/12 at 10:4 the new ECF of 12/5/12 at 12:5 was assessed choice of ECF. 12/5/12 at 4:30 Resident #A's contact the properties of the	0 A.MSS spoke with f Resident #A's choice. is completed with the the ECF staff indicated ess Resident #A that 5 P.MResident #A and accepted at his P.MSS notified daughter and updated					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	î î	(X3) DATE SURVEY COMPLETED		
I I I DI LINI	or conduction	155089	A. BUILDING			31/2013	
			B. WING STREET A	ADDRESS, CITY, STATE, ZIP	- CODE		
NAME OF P	ROVIDER OR SUPPLIER	₹		20TH ST			
HERITAC	BE HOUSE OF NEV	W CASTLE		ASTLE, IN 47362			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	E APPROPRIATE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE	
		e new ECF of his					
	choice.						
	A local hospita	l Discharge Summary					
	•	A dictated 12/13/12,					
		ollowing: Resident #A					
		itted on 12/1/12 and					
	discharged on	12/6/12. He was					
	evaluated and	treated for COPD					
	exacerbation.	Resident #A was					
	discharged to a new Long Term Care facility because his previous facility						
		him back. Resident					
		le condition at the time					
	of discharge.	•					
		cluded but were not					
	•	Budesonidine 0.5					
) in 2 ml inhalation					
	_	COPD. 2.) Spiriva					
		microgram (mcg) one					
	•	tion daily. 3.) Albuterol er 2.5 mg in 3 milliliters					
		saline every 4 hours as					
	` '	ortness of breath. 4.)					
		outerol 0.5 mg/3 mg					
	•	zed every 4 hours as					
		ortness of breath.					
							
	Resident #A w	as contacted and					
	interviewed on	1/30/13 at 12:50 P.M.,					
	and indicated t	the ECF's Administrator					
	and SSD went	to the hospital and					
		ne could not return to					
	_	y informed him he					
	needed to be s	somewhere that could					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155089	A. BUILDING 00 COMPLETED 01/31/2013				
		100009	B. WIN		DDDDGG GWW GW W GW	01/31/2	2013
NAME OF F	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE 20TH ST		
HERITAC	GE HOUSE OF NE	W CASTLE			ASTLE, IN 47362		
(X4) ID			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
	`				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	
PREFIX TAG	care for him. Fer the verbal notion him. Resident believed he was ECF because informed the Athey were not for Regulations resident he had voiced. On 1/30/13 at SSD indicated Administrator from 12/4/12, durate SSD indicated Administrator from 12/4/12, durate SSD indicated hospit Resident #A's him. The SSD was informed to meet his needs respiratory profindicated she for ECF to see if the therapists and not, and the nure sident standard to their facility did weekly, or as resident standard to their facility did weekly, or as resident standard to their facility did weekly, or as resident standard to their facility did weekly, or as resident standard to their facility did weekly, or as resident standard to the st	Resident #A indicated be came as a shock to #A indicated he as discharged from the he had previously dministrator and SSD following Federal lated to some concerns 1:24 P.M., the ECF's she and the had visited Resident #A ring his hospitalization. ated a SS staff from tal was present in room when they visited indicated Resident #A the facility could not a due to increased blems. The SSD had contacted a local hey staffed respiratory was informed they did urses cared for the		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE .	COMPLETION DATE
	the resident's r	espiratory needs. The					

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	of correction X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155089	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/31/2013	
	PROVIDER OR SUPPLIER GE HOUSE OF NEW CASTLE	STREET A 1023 N	ADDRESS, CITY, STATE, ZIP CO 20TH ST ASTLE, IN 47362	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE COMPI	X5) LETION TE
	DoN indicated the nursing staff questioned the Physician or NP for resident's respiratory needs.				
	On 1/31/13 at 11:02 A.M., the facility's Administrator indicated Resident #A was discharged from the facility because they could no longer meet his respiratory needs. She indicated the facility did not have RT on staff. She indicated they contracted RT services as needed. She indicated Resident #A needed to be in a facility that had RT staff available. She indicated their RT recommended Resident #A needed a facility with RT on staff. She indicated no other documentation related to not being able to meet Resident #A's needs or being considered for placement was available in Resident #A's record, prior to 12/4/12.				
	On 1/31/13 at 11:30 A.M., the DoN indicated Resident #A was his own responsible party and his daughter was his emergency contact and managed his finances.				
	This federal tag relates to complaint IN00122784.				
	3.1-12(a)(4)(A) 3.1-12(a)(4)(B)				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155089	A. BUILDING	00	COMP:			
	PROVIDER OR SUPPLIE	R	B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1023 N 20TH ST NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	SUMMARY S	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
IAU	3.1-12(a)(4)(C 3.1-12(a)(4)(D 3.1-12(a)(4)(E 3.1-12(a)(4)(F	() () ()	IAU			DATE		

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Facility ID: 000035

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155089		(X2) MI A. BUII		onstruction 00	(X3) DATE COMPI	LETED	
		155089	B. WIN	G		01/31	/2013
	PROVIDER OR SUPPLIER			1023 N	ADDRESS, CITY, STATE, ZIP CODI 20TH ST ASTLE, IN 47362	3	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
F0203 SS=D	TRANSFER/DISC Before a facility tr resident, the facili and, if known, a fa representative of or discharge and in writing and in a they understand; resident's clinical notice the items of (6) of this section Except when spe of this section, the discharge require this section must least 30 days before transferred or disc Notice may be may before transfer or of individuals in the endangered under the resident's hea allow a more immedischarge, under section; an immedis required by the needs, under para section; or a resid facility for 30 days The written notice (4) of this section for transfer or disc which the resident discharged; a stat has the right to ap	ansfers or discharges a any must notify the resident amily member or legal the resident of the transfer the reasons for the move a language and manner record the reasons in the record; and include in the lescribed in paragraph (a) (5)(ii) to enotice of transfer or dunder paragraph (a)(4) of the made by the facility at the resident is charged. The facility would be the fa					

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Facility ID: 000035

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	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		ONSTRUCTION 00	(X3) DATE S COMPL	ETED
		155089	B. WINC	3		01/31/	2013
	PROVIDER OR SUPPLIER		•	1023 N	NDDRESS, CITY, STATE, ZIP CODE 20TH ST ASTLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	Ī	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	ombudsman; for with development address and telep agency responsible advocacy of developmental D Bill of Rights Act; residents who are address and telep agency responsible advocacy of ment established under Advocacy for Ment established under the resident or family writing prior to give the resident or family writing prior to give the resident discharge, for sampled for discharge, for sampled for discharge included, but we chronic obstruction disease (COPE oxygen dependence). Resident #A's conticated Residen	r the Protection and ntally III Individuals Act. view and record lity failed to notify a ily of discharge in discharge and failed to nt a reason for I of 3 residents scharge. (Resident #A) e: record was reviewed 1:33 P.M. Diagnoses ere not limited to, ctive pulmonary D), pulmonary fibrosis, dence, and depression. quarterly Minimum issment dated 10/29/12,	F020	03	F203 1) Resident #A is no lor a resident of the facility. 2) All residents who are discharged from the facility have the poter to be affected. All residents; but transferred/discharged will be notified & if known, a family member or legal representative the resident will be notified by facility of the transfer or discharand the reasons for the move writing and in a language and manner they understand; recomber reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section (a)(5)(ii) of this section, the notice of transfer of discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the reside is transferred or discharged. Notice may be made as soon practicable before transfer or	e of the arge in t	02/18/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CQEJ11

Facility ID: 000035

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	LDING	00	COMPL	ETED
		155089	A. BUII B. WIN			01/31/	2013
		ı	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			20TH ST		
HERITA <i>(</i>	GE HOUSE OF NE\	N CASTLE			ASTLE, IN 47362		
	·						
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		iew for Mental Status,			discharge when the health of individuals in the facility would	l ho	
	which indicated	d he was cognitively			endangered under (a)(2)(iv) of		
	intact.				this section; the resident's hea		
					improves sufficiently to allow a		
	A RT (Respirat	tory Therapy) Progress			more immediate transfer or		
note for Resident #A dated 11/12/12				discharge, under paragrapher	(a)		
		ndicated the following:			(2)(i) of this section; an		
	· ·	vas notified by nursing			immediate transfer or discharg	ge	
	· ·	level positive airway			is required by the resident's		
		•			urgent medical needs, under		
	l ·	helps the user get			paragraph (a)(2)(ii) of this section; or a resident has not		
		neir lungs) order			resided in the facility for 30 da	vs	
		herapist reviewed and			The written notice specified in		
	verified the ord	lers. The settings were			paragraph (a)(4) of this section		
	changed to 14	/7 as ordered.			must include the reason for		
	Resident #A in	formed the therapist he			transfer or discharge; the		
		ssure settings should			effective date of transfer or		
	still be higher.	_			discharge; the location to whic	h	
		ident #A use the			the resident is transferred or		
		ered and evaluate after			discharged; a statement that t		
					resident has the right to appear the action to the State; the nar		
		5 days. Resident #A			address and telephone number		
	understood and	a agreed.			the State long term care	J. 01	
					ombudsman; for disabilities, th	ne	
	A Nurses note	for Resident #A dated			mailing address and telephone		
	12/1/12 at 7:05	5 A.M., indicated			number of the agency respons		
	Resident #A co	omplained of shortness			for the protection and advocad	cy of	
		oxygen saturation was			developmentally disabled		
		of oxygen. Resident			individuals established under	Part	
		as needed breathing			C of the Developmental	l of	
		as needed ativan for			Disabilities Assistance and Bil		
					Rights Act; and for nursing fact residents who are mentally ill,	-	
	1	der was received to			mailing address and telephone		
		#A to a local hospital			number of the agency respons		
	for evaluation a	and treatment.			for the protection and advocad		
					mentally ill individuals establis	-	
	A Social Service	ce (SS) note from the			under the Protection and		
		ndicated the following:			Advocacy for Mentally III		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155089	B. WIN			01/31/	2013
			D. 1111	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			20TH ST		
HERITA	GE HOUSE OF NE	W CASTLE			ASTLE, IN 47362		
			1		- ,		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
1710	†	P.MSS had been		1710	Individuals Act 3) All dischard	10	DATE
					residents will be monitored to	jC	
	_	e Social Service			ensure they have received the		
	•	D) at the Extended			required notification prior to		
	,	ECF), they would not be			discharge/ transfer. All resider	ıts;	
	accepting Resi	ident #A back upon			being transferred/discharged v		
	hospital discha	ırge.			be notified & if known, a family		
					member legal representative of		
	A Physician's t	yped note dated			the resident will be notified by facility of the transfer or discha		
	12/4/12, indica	ted the following:			and the reasons for the move	-	
		uffered from COPD.			writing and in a language and		
		equired respiratory			manner they understand; reco	rd	
		i-Pap. He was poorly			the reasons in the resident's		
		the Bi-Pap. His Bi-Pap			clinical record; and include in t	he	
					notice the items described in		
	_	be locked due to him			paragraph (a)(6) of this section	٦.	
	self adjusting t	•			Except when specified in paragraph (a)(5)(ii) of this		
		ders would be delayed			section, the notice of transfer	or	
		facility Respiratory			discharge required under	21	
	Therapy comp	any could come unlock			paragraph (a)(4) of this section	า	
	the machine a	nd change the setting.			must be made by the facility a	t	
	It was the phys	sician and facility's			least 30 days before the reside	ent	
	assessment, th	ney were not meeting		is transferred or discharged.			
	his needs from	a respiratory stand			Notice may be made as soon	as	
		he would be better			practicable before transfer or discharge when the health of		
	•	ility will full time on site			individuals in the facility would	he	
	respiratory the				endangered under (a)(2)(iv) of		
	l respiratory trie	тару.			this section; the resident's hea		
	A CC note for I	Resident #A dated			improves sufficiently to allow a	1	
					more immediate transfer or		
		P.M., indicated the			discharge, under paragraph (a		
	_	as concluded that			(i) of this section; an immediate		
		iratory needs could not			transfer or discharge is require by the resident's urgent medic		
	be met at this	•			needs, under paragraph (a)(2)		
		and Social Service			of this section; or a resident ha		
	Designee (SSI	D) had visited Resident			not resided in the facility for 30		
		ospital to inform him of			days. The written notice specif		
		"Staff expressed the			in paragraph (a)(4) of this sect	ion	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIC	00	COMPL	ETED
		155089	A. BUII B. WIN	LDING		01/31/	2013
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t			20TH ST		
HEDITA	GE HOUSE OF NEV	N CASTI E			ASTLE, IN 47362		
HENHA		W CASTLE		INEVV	ASTLE, IN 47302		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		nt and that his personal			must include the reason for		
	belongings wo	uld be transferred to			transfer or discharge; the effective date of transfer or		
	the receiving fa	acility. Resident			discharge; the location to which	h	
	seemed relucta	ant at first but soon			the resident is transferred or	11	
	began to accer	ot that his needs could			discharged; a statement that the	ne	
		fficiently at another			resident has the right to appea		
	facility. Reassurance offered."				the action to the State; the nar	ne,	
		daughter was notified			address and telephone number	er of	
		•			the State long term care		
	I	his decision with no			ombudsman; for disabilities, th		
	problem.				mailing address and telephone number of the agency respons		
					for the protection and advocac		
		the local hospital			developmentally disabled	,y 01	
		ollowing: 12/4/12 at			individuals established under l	⊃art	
	9:25 A.MResi	ident #A was seated at			C of the Developmental		
	the edge of the	e bed. He was alert,			Disabilities Assistance and Bil		
	oriented, and a	ble to make informed			Rights Act; and for nursing fac		
	decisions. He	had confirmed he			residents who are mentally ill,		
	wanted to retur	n to the ECF he had			mailing address and telephone		
		ed to the hospital from.			number of the agency respons for the protection and advocac		
		ed continuous oxygen			mentally ill individuals establis		
		treatments at the ECF.			under the Protection and		
	_				Advocacy for Mentally III		
	•	urse Practitioner (NP)			Individuals Act 4) Social		
		e was not a need for			Services will monitor all		
		be in a facility where			discharge/tranfers to ensure the	ney	
	there was a R1	· · · · · · · · · · · · · · · · · · ·			have received the required	_	
		ch had been the			notification. The Social Service Designee or their designee will		
	recommendation	on of the ECF. SS			responsible for auditing all fac		
	would follow-up	o with the ECF since			transfer/discharge residents.		
	Resident #A w	ished to return there			They will audit for 90 days all		
	upon discharge	e.			discharge/transfer; then weekl		
		P.MSS spoke with			for 4 weeks, then monthly for t	:WO	
		of Nursing (DoN) and			months, then as needed. Any		
		SS was informed the			discrepancy will be reported to	0	
					the QA Committee in the		
		be accepting Resident			Quarterly QA Meeting		
	#A back due to	his respiratory needs,					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155089	B. WIN	G		01/31/	2013
NAME OF P	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					20TH ST		
HERITAC	GE HOUSE OF NEV	V CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	e ECF was aware the					
		g his hospital care, had					
		ould not be necessary					
		nt #A in a ECF with a					
		as medically cleared					
		was present when the					
	ECF Administra	ator and SSD					
	presented to in	form Resident #A they					
	would not be a	ccepting him back.					
	12/4/12 at 5:50	P.MSS had received					
	a referral from	nursing related to					
	Resident #A's r	mental/emotional state.					
	Resident #A wa	as upset and anxious					
	because the E0	CF was not accepting					
	him back. Res	ident #A had stated					
	the ECF had be	een his home for 3					
	years and his f	riends, caregivers, and					
	•	ad become like family					
	_	nt #A had been tearful.					
	Resident #A ha	ad indicated he had the					
	Ombudsman's	phone number and					
		here was more to his					
		pted back to the ECF					
		itory care needs.					
	•	ad spoken with his					
		he had indicated she					
	_	the ECF was not					
		back. SS discussed					
		esident #A regarding					
		admission to another					
	,	sed the importance of					
		h physician orders to					
	•	s that was an issue					
	•	vious ECF in regards					
		m back to their facility.					
	Lo docepting mi	Such to their facility.					

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Event ID: CQEJ11

Facility ID: 000035

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155089	A. BUI	LDING	00	COMPLETED 01/31/2013
		100009	B. WIN		DDDDGG GWW GW W GOT	01/01/2010
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE 20TH ST	
HERITAC	GE HOUSE OF NEV	V CASTLE			ASTLE, IN 47362	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
TAG		· · · · · · · · · · · · · · · · · · ·		IAG	DLI ICILICI I	DATE
		A.MSS spoke with He had voiced his				
		ted to his previous ECF				
		nim back. He was				
		der other facilities. A				
	•	mpleted for another				
		ch was Resident #A's				
	first choice of r					
		0 A.MSS spoke with				
		f Resident #A's choice.				
		as completed with the				
		the ECF staff indicated				
		ess Resident #A that				
	day.					
	1	55 P.MResident #A				
		and accepted at his				
	choice of ECF.	•				
	12/5/12 at 4:30	P.MSS notified				
	Resident #A's	daughter and updated				
	her on his disc	harge plans.				
	12/6/12 at 3:00	P.MResident #A was				
	released to the	new ECF of his				
	choice.					
		l Discharge Summary				
		A dictated 12/13/12,				
		ollowing: Resident #A				
		tted on 12/1/12 and				
		12/6/12. He was				
		treated for COPD				
		Resident #A was				
		a new Long Term Care				
		e his previous facility				
	would not take	him back. Resident				
	#A was in stab	le condition at the time				

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Event ID: CQEJ11

Facility ID: 000035

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155089	(X2) MULTIPLE CC A. BUILDING	00	COM	TE SURVEY MPLETED 31/2013
		1 3	B. WING	ADDRESS STATE STATE		- · · •
NAME OF I	PROVIDER OR SUPPLIER	3		ADDRESS, CITY, STATE, ZIP	CODE	
LIEDITA/	SE HULIGE VE NEV	N/CASTLE		20TH ST		
HERITAG	GE HOUSE OF NE		INEVV C	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	of discharge.	-				
		cluded but were not				
	· ·	Budesonidine 0.5				
) in 2 ml inhalation				
	twice a day for	COPD. 2.) Spiriva				
	HandiHaler 18	microgram (mcg) one				
	capsule inhala	tion daily. 3.) Albuterol				
	sulfate nebuliz	er 2.5 mg in 3 milliliters				
	(ml) of normal	saline every 4 hours as				
	needed for sho	ortness of breath. 4.)				
	Ipratropium/alb	outerol 0.5 mg/3 mg				
		zed every 4 hours as				
		ortness of breath.				
	Resident #A w	as contacted and				
		1/30/13 at 12:50 P.M.,				
		the ECF's Administrator				
		to the hospital and				
		ne could not return to				
	· •	y informed him he				
		somewhere that could				
		Resident #A indicated				
		n't changed. Resident				
		ne Federal Law				
	1	receive a written				
		should have had 30				
	days to appeal					
		e received was the				
	verbal notice a					
		dicated the verbal				
	notice came as	s a shock to him.				
	Resident #A in	dicated he believed he				
	was discharge	d from the ECF				
	because he ha	d previously informed				
		tor and SSD they were				

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Event ID: CQEJ11

Facility ID: 000035

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	00	(X3) DATE SURVEY COMPLETED
	155089	A. BUILDING B. WING		01/31/2013
			ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER	1023 N	20TH ST	
HERITA	GE HOUSE OF NEW CASTLE	NEW C	ASTLE, IN 47362	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	
	not following Federal Regulations			
	related to some concerns he had			
	voiced.			
	On 1/30/13 at 1:24 P.M., the SSD			
	indicated she and the Administrator			
	had visited Resident #A on 12/4/12, during his hospitalization. The SSD			
	indicated a SS staff from the local			
	hospital was present in Resident #A's			
	room when they visited him. The			
	SSD indicated Resident #A was			
	informed the facility could not meet			
	his needs due to increased			
	respiratory problems. The SSD			
	indicated she had contacted a local			
	ECF to see if they staffed RT and was			
	informed they did not, and the nurses cared for the resident's respiratory			
	needs. The SSD indicated Resident			
	#A had not been notified he could not			
	return to the facility until the			
	hospitalization visit on 12/4/12. The			
	SSD indicated Resident #A had not			
	received a Notice of Transfer or			
	Discharge when he was transferred to			
	the hospital. The SSD indicated			
	residents should be given a copy of			
	the facility's Notice of Transfer or			
	Discharge when they are discharged to the hospital.			
	to the hospital.			
	On 1/31/13 at 10:05 A.M., the			
	Director of Nursing (DoN) at the ECF			
	Resident #A was discharged to from			

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			ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155089	B. WIN	G		01/31/	2013
NAME OF P	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	NO VIDEN ON SOLVEIEN				20TH ST		
HERITAC	GE HOUSE OF NEV	V CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	· ·	12/6/12, indicated					
	,	not have any daily,					
	weekly, or as n	eeded RT staff. The					
	DoN indicated	the nurses take care of					
	the resident's r	espiratory needs. The					
	DoN indicated	the nursing staff					
	questioned the	Physician or NP for					
	resident's resp	iratory needs.					
	On 1/31/13 at	11:02 A.M., the					
	facility's Admin	istrator indicated					
	Resident #A wa	as discharged from the					
	facility because	e they could no longer					
	meet his respir	atory needs. She					
	indicated the fa	acility did not have RT					
	on staff. She ii	•					
		services as needed.					
	She indicated I	Resident #A needed to					
		hat had RT staff					
		indicated their RT					
	recommended	Resident #A needed a					
	facility with RT						
		dent #A received his					
		ce verbally on 12/4/12,					
	_	ospitalized and did not					
		ng in writing, prior to or					
		indicated she was					
	unable to locat						
		charge to the hospital					
		Resident #A's record.					
		there was only a blank					
		tice of Transfer and					
		esident #A's record.					
	_	no other documentation					
	related to the la	acility not being able to					

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Event ID: CQEJ11

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION 00	COM	TE SURVEY IPLETED
		155089	B. WING		_	31/2013
NAME OF I	PROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZI N 20TH ST	IP CODE	
	GE HOUSE OF NEV	V CASTLE		CASTLE, IN 47362		
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TI DEFICIENCY	HE APPROPRIATE	COMPLETION DATE
TAG	meet Resident considered for available in Reprior to 12/4/12 local hospital to #A's placement ECF and the fain that planning. The facility did documentation record a Notice Discharge had confirm Reside of the Notice of Discharge, whe to the hospital of the Notice of Discharge, whe to the hospital of the Notice of Discharge paramaged his find A blank copy or Discharge paramaged h	not provide from Resident #A's of Transfer and been completed, or nt #A received a copy Transfer and en he was transferred on 12/1/12. In 1:30 A.M., the DoN dent #A was his own rty and his daughter ency contact and mances. If the Notice of Transfer rovided by the SSD on P.M., included blank ation to be filled out by ording where the be transferred from,	TAG	DEFICIENCY		DATE

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2013 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155089	A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 01/31/2013				
		B. WING STREET ADDRESS, CI				
	PROVIDER OR SUPPLIER SE HOUSE OF NEW CASTLE	1023 N 20TH ST NEW CASTLE, IN				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CO	VIDER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
	a resident, and bed hold information.					
	This federal tag relates to complaint IN00122784.					
	3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(ii)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CQEJ11

Facility ID: 000035

If continuation sheet

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